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DATE: 11/10/2021

TO: Interested Parties

FROM: Michelle Probert, Director, MaineCare Services

SUBJECT: Proposed Rule: 10-144 C.M.R. Chapter 101, MaineCare Benefits Manual, Section 97, Private Non-Medical Institutions, Ch. III

PUBLIC HEARING: No public hearing scheduled. The Department will be providing a 30-day comment period instead of a public hearing.

COMMENT DEADLINE: Comments must be received by 11:59 PM December 10, 2021.

This letter gives notice of proposed rule: 10-144 C.M.R. ch. 101, MaineCare Benefits Manual, Section 97, Private Non-Medical Institutions, Ch. III.

The Department of Health and Human Services (the "Department") proposes the following major substantive rule changes in 10-144 C.M.R. Ch. 101, MaineCare Benefits Manual, Chapter III, Section 97, Private Non-Medical Institution Services, including Ch. III (the "Main Rule") and Appendices B (Substance Abuse Treatment Facilities) and D (Child Care Facilities).

In Chapter III, the Department proposes to update the Main Rule and corresponding Appendices B and D to support the final adopted changes in Chapter II, Section 97 (effective Nov. 1, 2021), with the emergency major substantive rules intended to be filed simultaneously. The Ch. II rule changes implement various new requirements for Appendix D providers per the Family First Prevention Services Act (FFPSA), and also add new covered MaineCare services. Ch. II also imposes new requirements on Appendix B providers and broadens those covered services.

In recognition of these new requirements, the Department proposes these major substantive reimbursement rate increases. The new rates were authorized by the Legislature pursuant to P.L. 2021, Ch. 29, *An Act Making Unified Appropriations and Allocations for the Expenditures of State Government, General Fund and Other Funds and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2022 and June 30, 2023* (the "Budget") and P.L. 2021, Ch. 398, *An Act Making Unified Appropriations and Allocations for the Expenditures of State Government, General Fund and Other Funds and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2021, June 30, 2022 and June 30, 2023* (the "Supplemental Budget"). The rates are also consistent with independent rate studies completed for Appendix B and Appendix D services.

Section GGGG-1 of the Supplemental Budget provided the Department with authority to enact these changes on an emergency basis, without the need to make findings in support of an emergency per 5 M.R.S. § 8054. The Department filed the emergency major substantive rule changes on November 1, 2021, which shall be effective for up to 12 months or until the Legislature has completed review of the provisionally adopted major substantive rule per 5 M.R.S. § 8073. Through this major substantive rule

proposal, the Department is taking the first step toward making the emergency changes permanent. Following review of comments on the proposed rule changes, the Department shall send the provisionally adopted major substantive rule to the Legislature for review, per 5 M.R.S. § 8072. The Department shall seek approval from the Centers for Medicare and Medicaid Services (CMS) for the increased Appendix B and Appendix D rates.

In addition to the above, the Main Rule and relevant Appendices propose name changes to certain services in order to gain consistency with Chapter II, including updating “Crisis Residential” services to “Crisis Stabilization” services, “Treatment Foster Care” to “Therapeutic Foster Care,” and “Substance Abuse treatment” to “Substance Use treatment.”

Appendix B proposes rate updates from an independent rate study, recommending substantial increases, consistent with appropriations approved in the Supplemental Budget. Additional changes are proposed to ensure that the terminology in Appendix B is consistent with what is utilized in the finally adopted Ch. II rule, for example, “Detoxification” programs are now referred to as “Medically Supervised Withdrawal Services.” This rulemaking proposes creating two tiers of reimbursement, one tier accounting for all medical personnel, and another tier as an exception rate for low nursing staff, given substantial workforce challenges. Lastly, service components of the rate in 2400.1 are proposed to clarify that social workers are licensed clinical social workers and to add licensed marriage and family therapists, to align with changes adopted in Chapter II.

Appendix D proposes changing the name from “Childcare Facilities” to “Children’s Residential Care Facilities” in order to align with changes adopted in Chapter II. In Section 2400.1, board certified behavioral analyst services, board certified assistant behavior analyst services, and registered behavior technician services are proposed to align with changes in Chapter II. Following the independent rate study, rate recommendations are proposed, including consolidating Mental Health Level I and Level II services into a single Mental Health level of reimbursement, and consolidating Intellectual Disabilities and Autism Spectrum Disorder Levels I and II into a single Intellectual Disabilities/Developmental Disabilities residential treatment rate. Due to the rate changes and finally adopted changes in Chapter II, Section 97, this rule proposes removing language from Section 6000 because the referenced member assessment is no longer required. Chapter III also proposes rates for a proposed new MaineCare covered service, Aftercare Services, for the service itself and for mileage reimbursement. Aftercare is a required component of the FFPSA, and establishing the rate is necessary in order to meet the requirements of the FFPSA and the changes adopted in Chapter II, Section 97. The Department shall seek approval from CMS for the new Aftercare Services and the additional practitioners allowable under this Appendix.

Finally, in order to be consistent with the changes that will be finally adopted in Ch. II, effective Nov. 1, 2021, this rule proposes necessary updates to further address potentially stigmatizing language pursuant to P.L. 2017, ch. 407, and to update references to the Office of Behavioral Health from the Office of Substance Abuse.

Rules and related rulemaking documents may be reviewed at, or printed from, the MaineCare website at <http://www.maine.gov/dhhs/oms/rules/index.shtml> or for a fee, interested parties may request a paper copy of rules by calling (207) 624-4050 or Maine Relay number 711.

A concise summary of the proposed rule is provided in the Notice of Agency Rulemaking Proposal, which can be found at <http://www.maine.gov/sos/cec/rules/notices.html>. This notice also provides information regarding the rulemaking process. Please address all comments to the agency contact person identified in the Notice of Agency Rulemaking Proposal.

Notice of Agency Rule-making Proposal

AGENCY: Department of Health and Human Services, MaineCare Services, Division of Policy

CHAPTER NUMBER AND TITLE: 10-144 C.M.R. Chapter 101, MaineCare Benefits Manual, Section 97, Private Non-Medical Institutions, Ch. III

PROPOSED RULE NUMBER:

CONCISE SUMMARY:

The Department of Health and Human Services (the “Department”) proposes the following major substantive rule changes in 10-144 C.M.R. Ch. 101, MaineCare Benefits Manual, Chapter III, Section 97, Private Non-Medical Institution Services, including Ch. III (the “Main Rule”) and Appendices B (Substance Abuse Treatment Facilities) and D (Child Care Facilities).

In Chapter III, the Department proposes to update the Main Rule and corresponding Appendices B and D to support the final adopted changes in Chapter II, Section 97 (effective Nov. 1, 2021), with the emergency major substantive rules intended to be filed simultaneously. The Ch. II rule changes implement various new requirements on Appendix D providers per the Family First Prevention Services Act (FFPSA), and also add new covered MaineCare services. Ch. II also imposes new requirements on Appendix B providers and broadens those covered services.

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Section GGGG-1 of the Supplemental Budget provided the Department with authority to enact these changes on an emergency basis, without the need to make findings in support of an emergency per 5 M.R.S. § 8054. The Department filed the emergency major substantive rule changes on November 1, 2021, which shall be effective for up to 12 months or until the Legislature has completed review of the provisionally adopted major substantive rule per 5 M.R.S. § 8073. Through this major substantive rule proposal, the Department is taking the first step toward making the emergency changes permanent. Following review of comments on the proposed rule changes, the Department shall send the provisionally adopted major substantive rule to the Legislature for review, per 5 M.R.S. § 8072. The Department shall seek approval from the Centers for Medicare and Medicaid Services (CMS) for the increased Appendix B and Appendix D rates.

In addition to the above, the Main Rule and relevant Appendices propose name changes to certain services in order to gain consistency with Chapter II, including updating “Crisis Residential” services to “Crisis Stabilization” services, “Treatment Foster Care” to “Therapeutic Foster Care,” and “Substance Abuse treatment” to “Substance Use treatment.”

Appendix B proposes rate updates from an independent rate study, recommending substantial increases, consistent with appropriations approved in the Supplemental Budget. Additional changes are proposed to ensure that the terminology in Appendix B is consistent with what is utilized in the finally adopted Ch. II rule, for example, “Detoxification” programs are now referred to as “Medically Supervised Withdrawal Services.” This rulemaking proposes creating two tiers of reimbursement, one tier accounting for all medical personnel, and another tier as an exception rate for low nursing staff, given substantial workforce challenges. Lastly, service components of the rate in 2400.1 are proposed to clarify that social workers are licensed clinical social workers and to add licensed marriage and family therapists, to align with changes adopted in Chapter II.

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Finally, in order to be consistent with the changes that will be finally adopted in Ch. II, effective Nov. 1, 2021, this rule proposes necessary updates to further address potentially stigmatizing language pursuant to P.L. 2017, ch. 407, and to update references to the Office of Behavioral Health from the Office of Substance Abuse.

See <http://www.maine.gov/dhhs/oms/rules/index.shtml> for rules and related rulemaking documents.

STATUTORY AUTHORITY: 22 M.R.S. §§ 42, 3173; 22 M.R.S. § 8110; 42 U.S.C. § 671(20); P.L. 2019, ch. 407; The Family First Prevention Services Act, Public Law 115-123 (as part of Division E in the Bipartisan Budget Act of 2018 (H.R. 1892) (eff. Feb. 9, 2018) (as Amended through P.L. 116–260, enacted December 27, 2020); P.L. 2021, Ch. 398

PUBLIC HEARING: No public hearing scheduled. The Department will be providing a 30-day comment period instead of a public hearing.

DEADLINE FOR COMMENTS: Comments must be received by 11:59 PM December 10, 2021.

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IMPACT ON MUNICIPALITIES OR COUNTIES (if any): The Department anticipates that this rulemaking will not have any impact on municipalities or counties.

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GENERAL PROVISIONS

1000 PURPOSE

The purpose of these regulations is to define which items of expense will be taken into account and which will be excluded in the calculation of reasonable costs for Private Non-Medical Institutions. These Principles of Reimbursement for Private Non-Medical Institutions identify which costs are reimbursed under Chapter II, Section 97 - Private Non-Medical Institution (herein after, PNMI) Services of the *MaineCare Benefits Manual*. The Department will consider allowable costs identified by these Principles for reimbursement of services in a children's residential ~~child~~ care facility, substance ~~abuse~~ use disorder treatment facility, and community residences for persons with mental illness (for those facilities covered under Appendices B, D, and E) on the first day of the provider's fiscal year beginning on or after July 1, 2001. The Department will consider allowable costs identified by these Principles of Reimbursement for Private Non-Medical Institution medical and remedial facility services (under Appendices C and F) rendered on or after July 1, 2001. Prior to July 1, 2001, PNMI services rendered in a medical and remedial facility and non-case mixed medical and remedial facility shall follow the applicable appendix in effect prior to July 1, 2001, and the Principles of Reimbursement for Residential Care Facilities- Room and Board Costs.

1100 SCOPE/AUTHORITY

These Principles define scope and authority within the specific Appendix applicable to that type of Private Non-Medical Institution. These Principles define Department and member/resident in Section 10000 of this policy. These Principles define facility in each specific Appendix.

1300 ADULT FAMILY CARE HOMES

1300.1 The Department does not use these PNMI Principles in the determination of reimbursable amount paid to Adult Family Care Homes.

1400 REQUIREMENTS FOR MAINECARE REIMBURSEMENT

1400.1 In order to be reimbursed, all PNMI's identified as children's residential ~~child~~ care, substance ~~abuse-use~~ treatment, community residences for persons with mental illness, and Appendix F scattered site PNMI's for people for intellectual disabilities must be licensed as applicable, in accordance with the Mental Health Agency Licensing Standards and Rights of Recipients of Mental Health Services, Regulations for Licensing and Certification of Alcohol and Drug treatment Services, or Rules for the Licensure of Residential Child Care Facilities/Rights of Recipients of Mental Health Services Who are Children in Need of Treatment. In order to be reimbursed, medical and remedial service PNMI's and non-case mixed must be licensed by the Division of Licensing and Certification in the Department of Health and Human Services (See 10-149

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1400 **REQUIREMENTS FOR MAINECARE REIMBURSEMENT** (cont.)

C.M.R., Ch. 113). Appendix F, scattered site PNMI for persons with intellectual disabilities, may be licensed as either a residential care facility or as a mental health provider in accordance with the Mental Health Agency Licensing Standards and Rights of Recipients of Mental Health Services, Regulations for Licensing and Certification of Alcohol and Drug treatment services.

1400.2 All PNMI must obtain licensure and a signed Provider/Supplier Enrollment Agreement with the Department of Health and Human Services, Office of MaineCare Services (OMS). Providers must submit a copy of the license accompanying the Provider/Supplier Enrollment Agreement to the Department.

1400.3 Types of PNMI considered for MaineCare reimbursement, subject to the availability of funds, include:

1400.3.1 Facilities providing Private Non-Medical Institution services to members with significant mental or physical disability requiring structured, individualized habilitative or rehabilitative in-home programming as outlined in the provider agreement with the PNMI.

1400.3.2 Facilities with licensed Private Non-Medical Institution beds at scattered locations serving a minimum of four eligible members, as long as the service provided consistently fits within the definition of the applicable appendix stated below.

Appendix B Substance ~~Abuse-Use~~ Treatment Facilities
Appendix D Child~~ren's Residential~~ Care Facilities
Appendix F Non-Case Mixed Medical and Remedial PNMI

1400.4 Except for Child~~ren's Residential~~ Care Facilities covered under Appendix D, the Department will reimburse PNMI for services provided to eligible members based on an interim rate that the Department establishes and determines as reasonable and adequate to meet the costs that are incurred by an efficiently and economically operated facility in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. Appendix D standard rates are not interim and are not subject to cost settlement guidelines detailed in this Chapter.

1400.5 The Department requires cost reimbursed facilities to submit annual cost reports as stated in Section 3300.

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1500 RESPONSIBILITIES OF OWNERS OR OPERATORS

The owners or operators of a Private Non-Medical Institution must prudently manage and operate a PNMI of adequate quality to meet its residents' needs. Neither the issuance of a per diem rate, nor final orders made by the Commissioner, nor a duly authorized representative may in any way relieve the owner or operator of a PNMI from full responsibility for compliance with the requirements and standards of the Department or Federal requirements and standards.

1600 DUTIES OF THE OWNER OR OPERATOR

In order to qualify for MaineCare reimbursement the owner or operator of a PNMI, or a duly authorized representative must:

- 1600.1 Comply with the provisions of Chapter I; and Chapters II, III, and the applicable Appendix of Section 97 of the *MaineCare Benefits Manual*.
- 1600.2 Submit master file documents and cost reports in accordance with the provisions of Sections 3100 and 3300 of these Principles. Children's Residential Care providers under Appendix D must also submit these documents and cost reports, which the Department utilizes in setting appropriate reimbursement rates.
- 1600.3 Maintain adequate financial and statistical records and make them available for inspection by an authorized representative of the Department, State, or the Federal government upon request.
- 1600.4 Assure that annual records are prepared in conformance with Generally Accepted Accounting Principles (GAAP), except where otherwise required.
- 1600.5 Assure that the construction of buildings and the maintenance and operation of premises and residential services comply with all applicable health and safety standards.
- 1600.6 Submit such data, statistics, schedules or other information that the Department requires in order to carry out its functions. Failure to supply the required documentation may result in the Department imposing the deficiency per diem rate described in Section 7000 of these Principles.

1700 COVERED SERVICES

See applicable section of Chapter II, Section 97, Private Non-Medical Institution Services.

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1900 TERMINATION UNDER TITLE XIX

Termination of participation in Title XIX will result in the provider being terminated simultaneously from financial participation under PNMI cost reimbursement.

Alternatively, termination of participation in cost reimbursement will result in the provider being terminated simultaneously from participation in Title XIX. Conditions that may result in termination of participation in MaineCare are listed in Chapter I of the *MaineCare Benefits Manual*. These conditions may result in termination of the provider contract to provide PNMI services:

- 1900.1 The Federal Government fails to provide agreed upon funds; or
- 1900.2 The State share of funds is unavailable; or
- 1900.3 The life, health, or safety of persons served is endangered, in the opinion of the Department; or
- 1900.4 The provider fails to submit fiscal or program reports on the prescribed dates; or
- 1900.5 Either the Department or the provider receives a written notice from the other for any reason stating that termination will occur in no later than 30 days; or
- 1900.6 The provider fails to meet the applicable licensing regulations after a reasonable time for correction, or if the provider fails to deliver services in accordance with the plan of care; or
- 1900.7 The license to operate is revoked by Department or court action, or if the facility's owner or its administrator is convicted of any crime related to operation of the facility; or
- 1900.8 The same services can be provided at a lower rate on a fee-for-service basis or if the per diem rate is greater than the rates that third party payers are paying for comparable services under comparable circumstances.

2000 ACCOUNTING REQUIREMENTS

- 2000.1 All financial and statistical reports must be prepared in accordance with Generally Accepted Accounting Principles (GAAP), consistently applied, unless specific variations are required by these principles.
- 2000.2 The provider must establish and maintain a financial management system that assures adequate internal control and accuracy of financial data, the safeguarding of assets and operational efficiency.
- 2000.3 The provider must report on an accrual basis, unless it is a State or municipal institution that operates on a cash basis, unless the Department and the Department providing the State share of MaineCare reimbursement approves

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2000 ACCOUNTING REQUIREMENTS (cont.)

exceptional circumstances. The provider whose records are not maintained on an accrual basis must develop accrual data for reports on the basis of an analysis of the available documentation. The provider must retain all such documentation for audit purposes.

- 2000.4 It is the duty of the provider to notify the Division of Audit within 5 days of any change in its customary charges to the general public. The provider may submit a rate schedule to the Department to satisfy this requirement if the schedule allows the Department the ability to determine with certainty the charge structure of the Private Non-Medical Institution.

2300 COST RELATED TO RESIDENT CARE

- 2300.1 In order to be allowable, compensation must be reasonable and for services that are necessary and related to PNMI services. The services must actually be performed and incurred by the PNMI or its contractors. Providers must report all compensation to all appropriate state and federal tax authorities to the extent required by law for income tax, social security, and unemployment insurance purposes.

Providers may not claim reimbursement for personal expenses unrelated to member care. Bonuses that are part of a written policy of the provider and which require some measurable and attainable employee job performance expectations are allowable. Bonuses based solely on the availability of any anticipated savings are not allowable.

- 2300.2 Costs incurred for PNMI services that are rendered in common to MaineCare residents as well as to non-MaineCare residents, will be allowed on a pro rata basis, unless there is a specific allocation defined elsewhere in these Principles.

2400 ALLOWABILITY OF COST

- 2400.1 Allowable costs shall include salaries and wages for direct service staff.

See applicable Appendix for each type of PNMI for the list of approved direct service staff:

Appendix B	Substance Abuse-Use Treatment Facilities
Appendix C	Medical and Remedial Service Facilities
Appendix D	Child ren's Residential Care Facilities
Appendix E	Community Residences for Persons with Mental Illness
Appendix F	Non-Case Mixed Medical and Remedial Facilities

- 2400.2 Allowable costs shall also include the following taxes and benefits applicable to direct service staff as defined in the applicable Appendix:

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2400 **ALLOWABILITY OF COST** (cont.)

Payroll taxes/unemployment payroll taxes
Health insurance
Dental insurance
Employer term life/disability insurance
Qualified retirement contributions
Worker's Compensation insurance

2400.3 The Department will approve the direct care staffing.

2400.3.1 The Department will determine the reasonableness of costs based on the budget submitted prior to the beginning of the provider's fiscal year, subject to final approval by the Office of MaineCare Services and the Department. The total amount approved in the budget will serve as a cap for reimbursement.

2400.3.2 A Rate Letter will inform the provider of the approved total cost cap and per diem rate based on a review of the submitted budget per Section 2400, Chapter III, General Provisions. For case mix facilities covered under Appendix C, the rate letter informs the agency of the Industry Price and Average Case Mix Index.

2400.4 Allowable costs may also include contract fees, which are fees paid in lieu of salary, paid for use of foreign exchange fellows, such as those participating in the ILEX international professional exchange program for social workers, in lieu of direct service staff as defined in the applicable appendix. Contract fees must be prior-approved by the Department, and must meet all staff qualifications. The Department will reimburse the provider for the contract fee, based on a calculation of hours worked by the foreign exchange fellow, at the salary, wages and taxes and benefits that would be allowable under these regulations for a comparable direct service staff working those hours. The Department will only reimburse up to the allowed contract fee amount, and will not reimburse any wages and benefits to the foreign exchange fellow other than reimbursing the allowable contract fee amount.

2400.5 Pending CMS approval, effective August 1, 2018, for the state fiscal year ending June 30, 2019, a special supplemental wage allowance shall be available to Appendix C PNMI's, for increases in wages and wage-related benefits in direct care and personal care cost components. An amount equal to ten percent (10%) of wages and associated benefits and taxes as reported on each facility's as-filed cost report for its fiscal year ending in calendar year 2016 shall be added to the cost per resident day in calculating each facility's prospective rate, notwithstanding any otherwise applicable caps or limits on reimbursement. This supplemental allowance shall be allowed and paid at final audit to the full extent that it does not cause reimbursement to exceed the

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2400 **ALLOWABILITY OF COST** (cont.)

facility's allowable costs per day each cost component that is settled in that fiscal year.

Providers must ensure that the increase in reimbursement rates effective August 1, 2018 is applied in full to wages and benefits for employees who provide direct services. Providers must document compliance with this requirement in their financial records and provide such documentation to the Department upon request.

2410 State-Mandated Service Tax: Effective July 1, 2004, allowable costs shall include a State-mandated service tax. The State-mandated service tax is a tax on the value of PNMI services, as defined in 36 M.R.S.A. §2552(1)(G).

2420 Program Allowance: See the applicable Appendix for the allowable program allowance. The maximum reimbursement amount allowed, including the program allowance, will not be greater than the total costs of the program.

2430 Certifying Other Qualified Staff (With exception for Appendix C and F facilities)
Training and experience requirements of other qualified staff may vary by definition. However, in all cases, other qualified staff including exchange fellows must be certified or approved by a specified State agency, or its designee, as meeting these requirements. (The specified State agency, or its designee, would be the agency approving the staff for the facility.) These certifications/approvals must be on file. The approval must be in writing and dated at the time the approval is made. This approval process must not be delegated to a provider. The PNMI provider may certify to the approving agency that employees have or will have the requisite training. However, the approving agency must provide the written approvals for the provider to maintain on file. MaineCare payments made for individuals who have not been approved provisionally or fully certified by the State agency, or its designee, are subject to recoupment.

2440 If these Principles do not set forth a determination of whether or not a cost is allowable or sufficiently define a term used, reference will be made first to the *Medicare Provider Reimbursement Manual* (HIM-15) guidelines followed by the Internal Revenue Service Guidelines in effect at the time of such determination if the HIM-15 is silent on the issues.

2450 Pending CMS approval, effective retroactive to November 1, 2017, Appendix C and F PNMIs that experience unforeseen and uncontrollable events during a year that result in unforeseen or uncontrollable increases in expenses, defined more specifically in the applicable Section 97 appendices, may request an adjustment to a prospective rate in the form of an extraordinary circumstance allowance (ECA).

2460 Pending CMS approval, effective retroactive to November 1, 2017, costs incurred by Appendix C and F PNMIs to comply with changes in federal or state laws, regulations and rules or local ordinances and not otherwise specified in rules adopted by the

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2400 ALLOWABILITY OF COST (cont.)

Department are considered reasonable and necessary costs. Reimbursement for these additional regulatory costs will be paid via a supplemental payment that is added to the per diem rate until the Department adjusts for the direct care and personal care services rates, as applicable, to fairly and properly reimburse facilities for these costs.

2470 Temporary High Intensity Staffing Services are reimbursed based on a direct care price. This direct care price is not subject to audit. The Temporary High Intensity Staffing Services remittances received will be removed from the total Direct Services Staff costs in determining the allowable cost for the PNMI rehabilitation and personal care direct service staff costs.

2500 NON-ALLOWABLE COSTS

An unallowable cost includes all costs not included in Section 2400.

2600 SUBSTANCE OVER FORM

The cost effect of transactions that have the effect of circumventing these rules may be adjusted by the Department on the principle that the substance of the transaction shall prevail over the form.

2700 RECORD KEEPING AND RETENTION OF RECORDS

2700.1 Providers must make all financial and member records available to representatives of the State of Maine, Department of Health and Human Services or the U.S. Department of Health and Human Services, or the Maine Attorney General's Office, as required by Section 2700.3.

The Department will give providers a three-day notice when requesting fiscal records.

2700.2 Each provider must maintain complete documentation, including accurate financial and statistical records, to substantiate the data reported on the cost report.

2700.3 Complete documentation means clear evidence of all of the financial transactions of the provider and affiliated entities, including but not limited to census data, ledgers, books, invoices, bank statements, canceled checks, payroll records, copies of governmental filings, time records, time cards, purchase requisitions, purchase orders, inventory records, basis of apportioning costs, matters of provider ownership and organization, resident service charge schedule and amounts of income received by service, Federal and State income tax information, asset acquisition, lease, sale, or any other action, franchise or management arrangement, or any other record which is necessary to provide

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2700 RECORD KEEPING AND RETENTION OF RECORDS (cont.)

the Commissioner with the highest degree of confidence in the reliability of the claim for reimbursement. For purposes of this definition, affiliated entities will extend to realty, management, and other entities for which any reimbursement is directly or indirectly claimed, whether or not they fall within the definition of related parties.

2700.4 The provider must maintain all such records for at least 5 years from the date of settlement of the final audit. The Division of Audit must keep all cost reports, supporting documentation submitted by the provider, correspondence, work papers and other analysis supporting audits for a period of three years. In the event of litigation or appeal involving rates established under these regulations, the provider and Division of Audit must retain all records that are in any way related to such legal proceeding until the proceeding has terminated and any applicable appeal period has lapsed.

2700.5 When the Department determines that a provider is not maintaining records as outlined above for the determination of reasonable cost in the PNMI, the Department, upon determination of just cause, may impose the deficiency rate as described in Section 7000 of these Principles.

2900 BILLING PROCEDURES

2900.1 Substance ~~abuse-use~~ treatment facilities, children's residential care facilities, and community residences for persons with mental illness will bill the Department of Health and Human Services and be reimbursed at the agreed rate in accordance with MaineCare billing instructions for the UB-92 Claim Form.

2900.2 Medical and remedial service facilities will bill the Department of Health and Human Services and be reimbursed at the agreed rate in accordance with MaineCare billing instructions for the UB-92 Claim Form.

2900.3 Claims cannot include dates of service that overlap the provider's fiscal years.

3000 REIMBURSEMENT METHOD

3000.1 The Department will reimburse facilities for services provided to members based on a rate that the Department establishes on a prospective basis and determines is reasonable and adequate to meet the costs incurred by an efficiently and economically operated facility. The provider must provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

3000.1.1 Except for Appendices B and D facilities, the Department will limit reimbursement to the approved amount in Section 2400. Appendices

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3000 **REIMBURSEMENT METHOD** (cont.)

B and D facilities receive a standard rate not subject to Section 2400
adjustments for allowability of cost.

3000.2 Rate Setting Procedures

See applicable Appendix for type of Private Non-Medical Institution:

Appendix B	Substance Abuse-Use Treatment Facilities
Appendix C	Medical and Remedial Service Facilities Participating in Case Mix
Appendix D	Child ren's Residential Care Facilities
Appendix E	Community Residences for Persons with Mental Illness
Appendix F	Non-Case Mixed Medical and Remedial Facilities

3000.3 Rate Adjustments For Facilities Under Appendices E and F

Facilities covered under Appendices E and F may request rate adjustments as necessary. The relevant Appendix details the process for such requests. The Department will not grant retroactive rate adjustments unless they are approved by the OMS and the Department under exceptional circumstances as determined by these two agencies.

3000.4 For out-of-state PNMI services provided by out-of-state providers, the Division of Financial Services will determine whether the rate paid to these providers will be either 1) based on the methodology set forth in this section, or 2) be the Medicaid rate of the state in which the PNMI services are provided.

The following is subject to CMS approval

Subject to
CMS approval
Effective
10/1/15

3000.5 An Appendix C PNMI that qualifies as a “remote island facility” under this section will receive a fifteen (15) percent supplemental payment in addition to their MaineCare rate. This increase will apply only to facilities located on an island not connected to the mainland by a bridge.

3100 **FINANCIAL REPORTING**

3100.1 Master File

When requested by the Department the provider must submit the following documents to the Office of MaineCare Services or its designee. Providers must update documents to reflect any changes. The Department will use the following documents to establish a master file for each facility in MaineCare:

3100.1.1 Copies of the articles of incorporation and bylaws, of partnership agreements of any provider or any entity related to the provider;

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3100 FINANCIAL REPORTING (cont.)

- 3100.1.2 Chart of accounts and procedures manual, including procurement standards;
- 3100.1.3 Plant layout;
- 3100.1.4 Terms of capital stock and bond issues;
- 3100.1.5 Copies of long-term contracts, including but not limited to leases, pension plans, profit sharing, and bonus agreements;
- 3100.1.6 Schedules for amortization of long-term debt and depreciation of plant assets;
- 3100.1.7 Summary of accounting principles, cost allocation plans, and step-down statistics used by the provider;
- 3100.1.8 Related party information on affiliations, and contractual arrangements;
- 3100.1.9 Tax returns of the Private Non-Medical Institution; and
- 3100.2.0 Any other documentation requested by the Department for purposes of establishing a rate.

If any of the items listed in Subsections 3100.1.1 through 3100.2.0 are not submitted in a timely fashion, the Department may impose the deficiency per diem rate described in Section 7000 of these Principles.

3300 UNIFORM COST REPORTS

- 3300.1 The Department requires all PNMI's to submit cost reports. Cost reports, as prescribed herein, must be mailed to the State of Maine, Department of Health and Human Services, Division of Audit, and to the Division of Financial Services, Office of MaineCare Services, 11 State House Station, Augusta, ME, 04333-0011. Those out-of-state providers who are using another state's Medicaid rate or have two or fewer MaineCare residents must obtain prior authorization from the OMS Division of Financial Services, # 11 State House Station, Augusta, Maine 04333-0011 to be exempted from filing a cost report. The facility's financial statements will be the basis for completing the cost report. The cost reports must be based on the fiscal year of the facility. If the provider determines from its as filed cost report that it owes money to the Department, a check equal to 100% of the amount owed to the Department must accompany the cost report. If the Department does not receive a check with the cost report, the Department may elect to offset, pursuant to State and

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3100 **FINANCIAL REPORTING** (cont.)

federal law, the current payments to the facility until the entire amount is collected from the provider.

3300.2 Forms/Electronic Media. The Department will supply annual cost report forms/electronic media for use by PNMI's in the State of Maine.

3300.3 Each PNMI in Maine must submit a completed annual cost report within five months of the end of each fiscal year on forms/media prescribed by the Division of Audit. If available, the PNMI will submit a copy of the cost report on a computer disk or electronically.

The inclusive dates of the reporting year are the 12-month period of each provider's fiscal year, unless advance authorization to submit a report for a lesser period has been granted by the Director of the Division of Audit. Failure to submit an acceptable cost report in the time prescribed above may result in the Department imposing the deficiency per diem rate described in Section 7000.

3300.4 Certification by operator. Each provider must examine the cost report and supporting schedules prepared for submission to the Department and must certify that the report is a true, correct, and complete statement prepared from the books and records of the provider. The owner or administrator of the PNMI must certify the cost report. If someone other than the owner or administrator prepares the return, the preparer must also sign the report.

3300.5 The provider must submit the Cost Report with required supporting documentation to the Division of Audit. Supporting documentation requirements are defined by the Division of Audit. Supporting documentation includes, at a minimum, financial statements and reconciliation of the financial statements to the cost report. All cost reports must bear original signatures.

Providers must also submit a copy of the cost report without supporting documentation to the Division of Financial Services at the Office of MaineCare Services.

3300.6 Cents are omitted in the preparation of all schedules except when inclusion is required to properly reflect per diem costs or rates.

3300.7 The Division of Audit may reject any cost report filing that does not comply with these regulations. In such case, the report will be deemed not filed, until refiled and in compliance. A rejected cost report will subject the provider to the deficiency per diem as stated in Section 7000.

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3300 UNIFORM COST REPORTS (cont.)

- 3300.8 Extension for filing of the cost report with the required supporting documentation beyond the prescribed deadline will only be granted under the regulations stated in the *Medicare Provider Reimbursement Manual* (HIM-15).
- 3300.9 When a provider fails to file an acceptable cost report by the required date, the Department will send the provider a notice by certified mail, return receipt requested, advising the provider that all payments will be suspended until an acceptable cost report is filed. Reimbursement will then be reinstated at the full rate from that time forward, but reimbursement for the suspension period will be at the deficiency rate as stated in Section 7000.

3400 SETTLEMENT OF COST REPORTS

3400.1 Uniform Desk Review

See applicable PNMI Appendix for uniform desk review procedures.

3400.2 Calculation of the Final Settlement

See Applicable Appendix for calculation of the final settlement. Calculation of the final settlement is subject to reimbursement methods, limits, and reductions set forth in this Section. Appendix D facilities are not subject to cost settlement.

3500 ADJUSTMENTS TO AUDIT SETTLEMENTS (Except for Appendices B and D)

- 3500.1 Finalized cost report determinations and decisions may be reopened and corrected when the Division of Audit finds new and material evidence submitted by the provider or discovered by the Department or evidence of a clear and obvious material error.
- 3500.2 Reopening means an affirmative action taken by the Division of Audit to re-examine the correctness of a determination or decision that is otherwise final. Such action may only be taken:
- 3500.2.1 At the request of either the Department or a provider, within the applicable time period set out in paragraph 3500.4; and,
- 3500.2.2 When the reopening may have a material effect (more than one percent) on the provider's MaineCare rate payments.

A correction is a revision (adjustment) in the Division of Audit's determination, otherwise final, that is made after a proper re-

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3500 **ADJUSTMENTS TO AUDIT SETTLEMENTS (Except for Appendices B and D)**
(cont.)

opening. The Division may make a correction, or require the provider to file an amended cost report.

3500.4 A re-opening of an audit may occur within three years from the date of notice containing the Division of Audit's determination, or the date of a decision by the Commissioner or a court. No time limit will apply in the event of fraud or misrepresentation.

3500.4.1 A cost report is settled if there is no request for reconsideration of the Division of Audit's findings made within the required time frame or, if such request for reconsideration was made and the Division of Audit has issued a final revised audit report.

3500.4.2 No final audit will be reopened, or any hearing allowed concerning matters contained in any final audit if three years following the date of the final audit settlement have passed. This limitation does not apply in the event of fraud or misrepresentation.

3600 **SETTLEMENTS OF OVERPAYMENTS OR UNDERPAYMENTS (Except for Appendices B and D)**

3600.1 Underpayments: If, at the time the audit is completed, the Department determines that it has underpaid a facility; the Department will pay the amount due and forward the result to the facility within thirty working days.

3600.2 Overpayments:

3600.2.1 If the Department has overpaid a provider, it will recover overpayments by offset, recoupment, or other methods allowed by law.

3600.2.2 The department may withhold payment on pending or future claims in an amount equal to the overpayment, pursuant to State and federal law. The amount may be withheld all at once or over a period of time established by the Department. Amounts are to be repaid within 90 days of the date the audit is finalized unless otherwise negotiated by the Department.

3600.2.3 If there are insufficient claims sent to the Department against which the Department can offset the amount of an overpayment, the Department will direct the provider to remit the payment in full. If repayment is not made, the Department may exercise any or all appropriate action against the provider and exercise all other civil remedies in order to recover the overpayments.

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4000 PUBLIC HEARING

The State of Maine will provide for public hearings as described MBM, Chapter I.

5000 WAIVER

The failure of the Department to insist, in any one or more instances, upon the performance of any of the terms or conditions of these Principles, or to exercise any right under these principles, or to disapprove of any practice, accounting procedure, or item of account in any audit, will not be construed as a waiver of future performance of the right.

The obligation of the provider with respect to future performance shall continue, and the Department shall not be stopped from requiring such future performance.

6000 POST AUDIT APPEAL PROCEDURES (Except for Appendices B and D)

6000.1 These provisions apply only to appeals after audit adjustment. See MBM, Chapter I for all other appeals procedures. A provider may administratively appeal an audit adjustment made by the Division of Audit.

6000.2 An administrative appeal will proceed in the following manner:

6000.2.1 Within sixty (60) days of receipt of an audit or other appealable determination, the facility must request, in writing, an informal review before the Director of the Division of Audit or his/her designee. The facility must forward, with the request, any and all specific information it has relative to the issues in dispute, note the monetary amount each issue represents and identify the appropriate principle supporting the request. Only issues presented in this manner and timeframe will be considered at an informal review or at a subsequent administrative hearing.

6000.2.2 The Director or his/her designee will notify the facility in writing of the decision made as a result of the informal review. If the facility disagrees with the results of the informal review, the facility may request an administrative hearing before the Commissioner or a presiding officer designated by the Commissioner. Only issues presented in the informal review will be considered at the administrative hearing. A request for an administrative hearing must be made, in writing, within sixty (60) days of receipt of the decision made as a result of the informal review.

6000.2.3 To the extent the Department rules in favor of the provider, the audit report will be revised.

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6000 POST AUDIT APPEAL PROCEDURES (Except for Appendices B and D) (cont.)

6000.2.4 To the extent the Department upholds the original determination of the Division of Audit, review of the results of the administrative hearing is available in conformity with the *Administrative Procedure Act*, 5 M.R.S.A. §11001 *et seq.*

7000 DEFICIENCY PER DIEM RATE (Except for Appendices B and D)

In addition to the deficiency rate, civil and/or monetary sanctions may be applied by the State agency responsible for licensing the facility when a facility is found not to have provided the quality of service or level of care required. The Department will reimburse at 90% of the provider's per diem rate, unless otherwise specified. This "deficiency rate" will be applied following written notification to the facility of the effective date of the reduced rate for any of the following service deficiencies:

- 7000.1 Staffing over a period of two weeks or more does not meet the Federal Certification and State Licensing requirements;
- 7000.2 Food service does not meet the Federal Certification and State Licensing requirements;
- 7000.3 Specific, documented evidence that the care provided does not meet the Federal Certification and State Licensing requirements. Such penalty to be effective no sooner than 30 days from written notification that such deficiencies exist;
- 7000.4 Failure to correct, within the time frames of an accepted Plan of Correction, deficiencies in meeting the Federal Certification and State Licensing requirements, which cause a threat to the health and safety of residents in a facility or the surrounding community;
- 7000.5 Failure to submit a cost report, financial statements, and other schedules as requested by the Division of Audit, and to maintain auditable records as required by these Principles and other relevant regulations may result in application of the deficiency per diem rate, suspension, withholding of, or recoupment of MaineCare reimbursement. The deficiency per diem rate for these items will go into effect immediately upon receipt of written notification from the Department.
- 7000.6 Failure to complete acceptable assessments, as defined in Appendix C.

A reduction in rate because of deficiencies will remain in effect until the deficiencies have been corrected, as defined in the applicable Appendix, or as verified by representatives of the Department, following written notification by the provider that the deficiencies no longer exist. No retroactive adjustments to the full rate will be made for the period that the deficiency rate is in effect

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7000 **DEFICIENCY PER DIEM RATE (Except for Appendices B and D) (cont.)**

unless the provider demonstrates to the satisfaction of the Department that there was no just cause for the reduction in payment.

8000 **START UP COSTS APPLICABILITY**

Prior to admitting residents, certain costs are incurred, which are referred to as start-up costs. No start-up costs can be allowed for the PNMI component.

9000 **GENERAL DEFINITIONS**

“Accrual Basis of Accounting” means that revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

“Allowable Costs” are those operating costs remaining after the adjustments required by the Principles have been applied to the provider’s total operating costs reported in the annual cost reports.

“Cash Basis of Accounting” means revenues are recognized only when cash is received and expenditures for expense and asset items are not recorded until cash is disbursed for them.

“Census/Days of Care”: For purposes of counting the number of patient days, the day of the patient's admission will be counted, but the day of discharge will not be counted.

“Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration (HCFA)” is the Agency within the U.S. Department of Health and Human Services (HHS) responsible for developing and implementing policies governing the Medicare and federal Medicaid programs.

“Common Ownership” exists if an individual or individuals possess 10% or more ownership or equity in the provider and the institution or organization serving the provider.

“Control” exists if an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

“Cost Finding” are the processes of segregating costs by cost centers and allocating indirect cost to determine the cost of services provided.

“Days of Care” are total days of care provided whether or not payment is received and the number of any other days for which payment is received. (Note: Discharge days are included only if payment is received for these days.)

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9000 **GENERAL DEFINITIONS** (cont.)

“Generally Accepted Accounting Principles (GAAP)” are those accounting principles with substantial authoritative support. In order of authority the following documents are considered GAAP: (1) FASB Standards and Interpretations, (2) APB Opinions and Interpretations, (3) CAP Accounting Research Bulletins, (4) AICPA Statements of Position, (5) AICPA Industry Accounting and Auditing Guides, (6) FASB Technical Bulletins, (7) FASB Concepts Statements, (8) AICPA Issues Papers and Practice Bulletins, and other pronouncements of the AICPA or FASB.

“Department” as used throughout these principles is the State of Maine Department of Health and Human Services.

“Division of Audit” used throughout these Principles refers to the Department of Health and Human Services, Division of Audit.

“MaineCare Eligible Days” are the actual days of service for which payment was made by the Office of MaineCare Services through the claims process.

“Necessary and Proper Costs” are costs for services and items that are essential to provide appropriate resident care and resident activities at an efficient and economically operated facility. They are costs for services and items that are commonly provided and are commonly accepted as essential for the type of facility in question.

“Occupancy Level” as referenced in this policy consists of the total licensed beds of a PNMI times the number of days available in the fiscal period (e.g.: A PNMI licensed for 10 beds and open for a full 12 month period, with the fiscal period covering the full 12 months, would have its occupancy level stated at 3650. Ten beds multiplied by 365 days in the year equals 3650 days.)

“Owners” include any individual or organization with 10% or more equity interest in the provider’s operation and any members of such individual’s family or his or her spouse’s family. Owners also include all partners and all stockholders in the provider’s operation and all partners and stockholders or organizations that have a 10% or more equity interest in the provider’s operation.

“Per Diem Rate” includes total allowable costs divided by days of care.

“Reasonable Costs” are those incurred by a provider which are reasonable and necessary in providing adequate care to eligible residents and which are within the requirements and limitations of this policy. The reasonableness and necessity of any costs will be determined by reference to, or in comparison with, the cost of providing comparable services.

“Related to the Provider” means that the provider to a significant extent is associated or affiliated with, has control of, or is controlled by the organization furnishing the services, facilities, and supplies.

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9000 **GENERAL DEFINITIONS** (cont.)

Subject to CMS
approval
Effective
10/1/15

“Remote Island Facility” for the purposes of this section, means a facility located on an island not connected to the mainland by a bridge.

“Resident” as used throughout this policy refers to the person residing in the facility and is receiving services in the PNMI. The term is also synonymous with “member.”

“Rider A” is used to denote the State’s share of funds used to draw down the federal Medicaid funds by a specific agency/facility. The form states the amount of State money available, the total federal match (Medicaid) that can be drawn down and the combined total (of State and Federal) that the agency/facility can receive in that fiscal year.

“State Licensing and Federal Certification” as used throughout these principles are the applicable “Regulations Governing the Licensing and Functioning of Level I Private Non-Medical Institutions,” “Regulations Governing the Licensing and Functioning of Level II Private Non-Medical Institutions,” “Regulations Governing the Licensing and Functioning of Level III Private Non-Medical Institutions,” or “Regulations Governing the Licensing and Functioning of Level IV Private Non-Medical Institutions”, “Mental Health Agency Licensing Standards and Rights of Recipients of Mental Health Services,” “Regulations for Licensing and Certifying of Alcohol and Drug Treatment Services,” or “Rules for the Licensure of Residential Child Care Facilities” and “Rights of Recipients of Mental Health Services Who are Children in Need of Treatment;” and the Federal Certification requirements for Private Non-Medical Institutions that are in effect at the time the cost is incurred.

“Leave (bedhold) days” are when the resident is not in the facility and no treatment is provided. Leave days are not a covered service.

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Established 6/11/90

FINAL-EMERGENCY ADOPTION

8/11/1911/1/21

PROC. CODE	DESCRIPTION * See Below	MAXIMUM ALLOWANCE EFFECTIVE 7/1/16 to 7/31/18*	MAXIMUM ALLOWANCE EFFECTIVE 8/1/18-6/30/19**	MAXIMUM ALLOWANCE EFFECTIVE 7/1/19**	MAXIMUM ALLOWANCE EFFECTIVE 11/1/21***
SUBSTANCE USE ABUSE TREATMENT FACILITIES					
H0010	Detoxification Medically Supervised Withdrawal Services	\$212.96 per diem	\$217.88 per diem	\$217.48 per diem	
<u>H0010</u>	<u>Medically Supervised Withdrawal Services (Non Hospital based – exception rate for low RN)</u>				<u>\$238.12 per diem</u>
<u>H0010 TD</u>	<u>Medically Supervised Withdrawal Services (Non Hospital based)</u>				<u>\$385.55 per diem</u>
H2034	Halfway House Services	\$103.89 per diem	\$106.30 per diem	\$106.09 per diem	<u>\$165.67 per diem</u>
H2036	Extended Care	\$114.46 per diem	\$117.11 per diem	\$116.89 per diem	<u>\$137.21 per diem</u>
H2036 HF	Residential Rehabilitation Type 1	\$219.78 per diem	\$224.87 per diem	\$224.44 per diem	<u>\$287.91 per diem</u>
H2034 HF	Residential Rehabilitation Type II	\$117.17 per diem	\$119.87 per diem	119.65 per diem	<u>\$165.67 per diem</u>
H2036 HA	Adolescent Residential Rehabilitation	\$183.77 per diem	\$188.02 per diem	\$187.67 per diem	<u>\$254.78 per diem</u>

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T1020 HF	Personal Care - Substance Abuse-Use (Substance Abuse-Use Shelter Services)	\$55.69 per diem	\$56.97 per diem	\$56.87 per diem	
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* Room and Board costs are not reimbursed in the rates for PNMI Substance ~~Abuse-Use~~ Treatment Service

The Department is seeking and anticipates receiving approval from CMS for this Section. Pending approval, the increased rates are effective retroactive to July 1, 2016 (for * rates, above) and August 1, 2018 (for rates **, above) for Appendix B, C, and E PNMI's.

The Department is seeking and anticipates receiving approval from CMS for this Section. Pending approval, the increased rates are effective retroactive to July 1, 2016 (for * rates, above) and August 1, 2018 (for ** rates, above) for Appendix B, C, and E PNMI's.

The Department shall seek approval from CMS for this Section (for the rates * above).**

RESIDENTIAL CHILD CARE FACILITY		
	Child Care Facility PNMI Services	Maximum Allowance Per Diem <u>to 10/31/21</u>
H0019-HE	Child Mental Health Level I*	\$330.72 per diem
H0019-CG	Child Mental Health Level II*	\$435.40 per diem
H0019-SE	Intellectual Disabilities and Autism Spectrum Disorder Level I*	\$396.47 per diem
H0019-U9	Intellectual Disabilities and Autism Spectrum Disorder Level II*	\$585.60 per diem
H0019-HA	Crisis Residential	\$539.89 per diem

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H0019-HU	Treatment Foster Care	\$103.51 per diem
H0019-HY	Treatment Foster Care-Multidimensional (Juvenile Justice)	\$150.45 per diem
S9484 HA	Temporary High Intensity Service for Children in ITRT Setting. This service is only available for Mental Health Level I and II and Intellectual Disabilities Level I and II	By Report per hour

The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, the increased rates will be effective retroactive to July 1, 2016 (for * rates, above) and August 1, 2018 (for ** rates, above) increased rates for Appendix B, C, and E PNMI's.

CHILDREN'S RESIDENTIAL CARE FACILITY – Effective 11/1/21		
	<u>Children's Residential Care Facility PNMI Services</u>	<u>Maximum Allowance Per Diem Effective 11/1/21</u>
<u>H0019-HE</u>	<u>Mental Health Residential Treatment Services</u>	<u>\$580.09 per diem***</u>
<u>H0019-HI</u>	<u>Intellectual Disabilities/Developmental Disabilities Residential Treatment Services</u>	<u>\$727.98 per diem***</u>
<u>H0019-HA</u>	<u>Crisis Stabilization</u>	<u>\$539.89 per diem</u>
<u>99510 HR</u>	<u>Aftercare Services - Service</u>	<u>\$53.34 per hour***</u>
<u>A0425 HI</u>	<u>Aftercare Services - Mileage</u>	<u>\$2.13 per mile***</u>

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<u>H0019-HU</u>	<u>Therapeutic Foster Care</u>	<u>\$103.51 per diem</u>
<u>H0019-HY</u>	<u>Therapeutic Foster Care-Multidimensional (Juvenile Justice)</u>	<u>\$150.45 per diem</u>
<u>S9484 HA</u>	<u>Temporary High Intensity Service for Children in ITRT Setting. This service is only available for Mental Health Level I and II and Intellectual Disabilities Level I and II</u>	<u>By Report per hour</u>

The Department shall seek approval from CMS for this Section (for the rates *** above).

COMMUNITY RESIDENCES FOR PEOPLE WITH MENTAL ILLNESS		
* (H0019)	Rehabilitation Services	By Report
* (T1020-HE)	Personal Care Services-Residences For People With Mental Illness	By Report
S9484 HE	Temporary High Intensity Service for Residents of Appendix E	By Report per hour

RESIDENTIAL CARE FACILITIES		
* (T1020)	Medical and Remedial Personal Care Services	By Report
* (T1020)	Medical and Remedial Services	By Report

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COMMUNITY RESIDENCES FOR PEOPLE WITH INTELLECTUAL DISABILITIES		
RMR* (T1020)	Personal Care Services-Residences For People With Intellectual Disabilities	By Report
MRP* (H0019)	PNMI Services	By Report
S9484 HI	Temporary High Intensity Service for Residents of Appendix F	By Report per hour

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INTRODUCTION

1000 PURPOSE

The purpose of Appendix B is to identify reimbursement regulations that are specific to substance ~~ab~~use treatment facilities under Chapter III, Private Non-Medical Institutions (PNMI) services of the MaineCare Benefits Manual. The general provisions of Chapter III for PNMI services contain reimbursement regulations that are applicable to all categories of service under the PNMI regulations. It shall be the prerogative of the Commissioner of the Department of Health and Human Services to impose a ceiling on reimbursement for private non-medical institutions. These regulations identify which costs are reimbursable within Section 97, Chapters II and III and Appendix B, Private Non-Medical Institution Services of the MaineCare Benefits Manual. As of November 15, 2010, Substance ~~Abu~~Use Treatment Facilities under this Appendix are reimbursed using a standard rate for each defined type of substance ~~ab~~use treatment service, and are not subject to establishment of interim rates and cost settlement procedures, as detailed in Section 97, Chapter III. Rates may be found at <http://www.maine.gov/dhhs/audit/rate-setting/index.shtml>.

1200 AUTHORITY

The authority of the Department of Health and Human Services to accept and administer funds which may be available from State and/or Federal sources for the provision of the services as set forth in Appendix B is contained in 22 MRSA Section 3173-D and Title XIX of the Social Security Act as Amended; 42 U.S.C.A. §1396 *et seq.*

1210 DEFINITIONS

The term “member” as used throughout this Appendix refers to an individual who has been determined to be eligible for MaineCare by the Department of Health and Human Services and who is receiving substance ~~ab~~use treatment by qualified staff of a Private Non-Medical Institution as defined in Section 97.01-1(A) of the MaineCare Benefits Manual.

The term “facility” as used throughout these Principles of Reimbursement refers to private non-medical institutions licensed and funded by the State of Maine, Department of Health and Human Services (DHHS) Office of ~~Substance Abuse Services (OSA)~~Behavioral Health under Sections 4.06, 4.08, 4.09, 4.10, 4.11 and/or 4.13 of the "Regulations for Licensing/Certifying of Substance Abuse Treatment Facilities in the State of Maine," but excludes any Department-licensed facilities staffed by a solo provider.

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2400 SERVICE COMPONENTS OF THE STANDARD RATE

Providers must follow all State of Maine licensing regulations and guidelines for staffing levels and must maintain professional staffing sufficient to serve the individual needs of each recipient as reflected in his individual service plan (as defined in Chapter II, §97.) Professional services may be provided only within the scope of the professional's license.

2400.1 The standard per diem rates provided for Detoxification (non-hospital based), Halfway House Services, Extended Care, Residential Rehabilitation Services (Type I), Residential Rehabilitation Services (Type II), Adolescent Residential Rehabilitation and Personal Care Substance ~~Ab~~U~~se~~ (Substance ~~Ab~~U~~se~~ Shelter Services) are intended to include the service costs listed below. Providers may not bill separately under this section or any other section of the MaineCare Benefits Manual for providing these services. Salaries and wages for direct service staff and services listed below:

Physicians
Psychiatrists
Psychologists
~~Licensed clinical S~~ocial workers
Licensed clinical professional counselors
Licensed professional counselors
Licensed marriage and family therapists
Registered nurses
Practical nurses
Licensed alcohol and drug counselors
Psychiatric nurses
Personal care services staff
Clinical Consultants
Other qualified alcohol and drug treatment staff as defined in Section 97.07-2, of the MaineCare Benefits Manual.

It is the responsibility of the PNMI to provide and coordinate all covered services performed by direct care staff listed in this Section to assure that members receive the full range of services necessary to meet members' needs without duplication of services. See MaineCare Benefits Manual (MBM), Chapter II, Section 97, Sections 97.04 and 97.05 regarding covered services and non-duplication of services.

2400.2 The Department shall determine the reasonableness of the treatment costs on an annual basis. Providers must submit any requested data to the Department including, but not limited to, utilization data.

2410 The rates in this Section include a State-mandated service tax. The State-mandated service tax is a tax on the value of PNMI services pursuant to 36 M.R.S. §2552. Since providers will no longer receive Rate letters detailing this information, they will need to calculate the service tax of reimbursed services.

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2400 **SERVICE COMPONENTS OF THE STANDARD RATE** (cont.)

2460 The total costs shall be allocated to rehabilitation and to personal care.

2500 **NON-ALLOWABLE COSTS**

Non-allowable cost includes all costs not included in Section 2400.

3400 **COST REPORTS**

3400.1 Uniform Desk Review

3400.1.1 The Division of Audit shall perform a uniform desk review of each acceptable cost report submitted.

3400.1.2 The uniform desk review is an analysis of the provider's cost report to determine the adequacy and completeness of the report, accuracy and reasonableness of the data recorded therein, and allowable costs.

3400.1.3 Based on the results of the uniform desk review, the Division of Audit may:

- a. Request more information,
- b. Issue a final report of findings, or
- c. Conduct a field audit and issue a final report of findings.

5120 **PERSONAL CARE SERVICES**

PNMI services approved and funded by ~~OSA-OBH~~ in licensed facilities may also provide personal care services necessary for the promotion of ongoing treatment and recovery. PNMI facilities must be receiving funds from ~~OSA-OBH~~, specifically for the provision of personal care services, in order to also be reimbursed by MaineCare for such services.

6000 **RATE SETTING**

6000.1

The Department is seeking and anticipates receiving approval from the federal Centers for Medicare and Medicaid Services for this Section. Pending approval, the following reimbursement rates will be effective retroactive to July 1, 2016* and August 1, 2018*** as indicated below:

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6000 **RATE SETTING (CONT.)**

The following capitated rates apply to Appendix B services.

SERVICE DESCRIPTION	AMOUNT Effective 7/1/16 to 7/31/18	AMOUNT Effective Retroactive to 8/1/18	AMOUNT Effective 7/1/19	AMOUNT Effective 11/1/21*	UNIT
Detoxification Medically Supervised Withdrawal Services (Non Hospital based)	\$212.96	\$217.88	\$217.48	<u>\$385.55</u>	per diem
Medically Supervised Withdrawal Services (Non Hospital based – exception rate for low RN)				<u>\$238.12</u>	<u>per diem</u>
Halfway House services	\$103.89	\$106.30	\$106.09	<u>\$165.67</u>	per diem
Extended Care	\$114.46	\$117.11	\$116.89	<u>\$137.21</u>	per diem
Residential Rehabilitation Type I	\$219.78	\$224.87	\$224.44	<u>\$287.91</u>	per diem
Residential Rehabilitation Type II	\$117.17	\$119.87	\$119.65	<u>\$165.67</u>	per diem
Adolescent Residential Rehabilitation	\$183.77	\$188.02	\$187.67	<u>\$254.78</u>	per diem
Personal Care Substance Abuse Use (Substance Abuse-Use Shelter Services)	\$55.69	\$56.97	\$56.87		per diem

The Department shall seek approval from CMS for this Section (for the rates * above).

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6000 **RATE SETTING (CONT.)**

Members are assessed as described in Chapter II, Section 97, and assigned to one of the types of substance ~~abuse-use~~ treatment services described above. Providers bill the Department on a per diem basis for each member receiving service. The capitated rate includes all PNMI services required by the member for his or her type of service including all staffing required pursuant to State of Maine licensing guidelines and as identified in the members individual service plan. There is no cost settlement for Appendix B PNMI services.

6000.2 The provider must submit, upon request, such data, statistics, schedules, or other information required by the OMS and ~~OSAQBH~~.

6000.3 The standardized rate for each Substance ~~abuse-use~~ treatment service type will begin November 15, 2010.

6000.4 Providers must ensure that the increase in reimbursement rates effective August 1, 2018 is applied in full to wages and benefits for employees who provide direct services. Providers must document compliance with this requirement in their financial records and provide such documentation upon request. The increase must be granted or paid out retroactively from the date the Department begins reimbursing the increased rates.

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CHILDREN'S RESIDENTIAL CARE FACILITIES
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1000 **PURPOSE**

The purpose of Appendix D is to identify reimbursement specific to Children's Residential Care Facilities, child placing agencies, ~~treatment-therapeutic~~ foster care providers, or Intensive Temporary Out of Home Treatment Services providers under Section 97, Chapter III, Private Non-Medical Institutions (PNMI) services of the *MaineCare Benefits Manual*. This Appendix identifies capitated rates for Children's Residential Care Facilities. As of August 1, 2009, Children's Residential Care Facilities under this appendix are reimbursed a capitated fee for services, and are not subject to establishment of interim rates, as detailed in Section 97, Chapter III.

1200 **AUTHORITY**

The authority of the Department of Health and Human Services to accept and administer funds that may be available from State and Federal sources for the provision of the services set forth in this Appendix of Reimbursement is contained in 22 M.R.S.A. Sec. 42 and Sec. 3173.

1210 **DEFINITIONS**

The term "member" as used throughout this Appendix refers to an individual who has been determined to be eligible for MaineCare by the Department of Health and Human Services and who is receiving mental health treatment and/or rehabilitative services as a resident of a children's residential care facility as defined in Section 97.01-1(B) of the *MaineCare Benefits Manual*.

The term "facility" as used throughout these Principles of Reimbursement refers to a children's residential care facility, as defined by Section 97.01-1(B) of the *MaineCare Benefits Manual*. Also, as stated in Section 97.01-1(B) for MaineCare reimbursement purposes, this term also includes child placing agencies and ~~treatment-therapeutic~~ foster care providers.

2400 **SERVICE COMPONENTS OF THE STANDARD RATE**

Providers must follow all State of Maine Licensing guidelines for staffing levels and must maintain specific staffing listed below sufficient to serve the individual needs of each child as identified in the child's individual service plan (as defined in Chapter II, Section 97) and approved by the Department. Staffing is also detailed in MBM, Chapter II, Section 97. Services may only be provided within scope of licensure for the respective professional.

2400.1 Appendix D PNMI services for: Intellectual Disabilities/Developmental Disabilities and Autism Spectrum Disorder Level I, Intellectual Disabilities and Autism Spectrum Disorder Level II, Child Mental Health Level I, and Crisis Stabilization Residential Services include the following components in the standardized rate, which may not be billed separately under this or other Sections of MaineCare:

- a. Psychiatrist services

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2400 **SERVICE COMPONENTS OF THE STANDARD RATE** (cont.)

- b. Psychologist services – treatment/not testing
- c. ~~Licensed clinical~~ Social worker services
- d. Licensed clinical professional counselor services
- e. Licensed professional counselor services
- f. Licensed practical nurse services
- g. Psychiatric nurse services
- h. Licensed alcohol and drug counselor services
- i. Behavioral Health Professional
- j. Pediatric Neurologist
- k. Other Qualified Mental Health Professional
- l. Behavioral Health Professional services
- m. Board certified behavior analyst services*
- n. Board certified assistant behavior analyst*
- o. Registered behavior technician services*

***The Department shall seek CMS approval for these changes.**

Appendix D PNMI services for ~~Treatment-Therapeutic~~ Foster Care include the following components in the standardized rate, which may not be billed separately under this or other Sections of MaineCare:

- a. ~~Treatment-Therapeutic~~ Foster Care Parents
- b. Licensed Social Worker Services
- c. Other Qualified Child Care Professional
- d. Other Qualified Child Care Facility Professional.

Direct service staff who meet residential licensing requirements are considered to be an allowable expense within an Appendix D facility.

It is the responsibility of the PNMI to provide and coordinate all covered services performed by direct care staff listed in this Section to assure that members receive the full range of services necessary to meet resident needs without duplication of services. See *MaineCare Benefits Manual* (MBM), Chapter II, Section 97, Sections 97.04 and 97.05 regarding covered services and non-duplication of services.

2400.2 The Department shall determine the reasonableness of the treatment costs on an annual basis. Providers must submit any requested data to the Department including but not limited to utilization data.

2400.3 Other qualified ~~treatment-therapeutic~~ foster care providers (Chapter 2, Section 97.07-2 of the *MaineCare Benefits Manual*). Reimbursement to foster parents for care of children in placement shall be limited to 60% of the wages and taxes/fringe benefits

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2400 SERVICE COMPONENTS OF THE STANDARD RATE (cont.)

(as defined under Sections 2400.1 and 2400.2 of this Appendix) or 60% of the stipend amounts as determined by the Department.

2410 The rates in this Section include a State-mandated service tax. The State-mandated service tax is a tax on the value of PNMI services pursuant to 36 M.R.S. §2552.

Since providers will no longer receive Rate letters detailing this information, they will need to calculate the service tax of reimbursed services.

3400 COST REPORTS

Appendix D services are not audited; however providers are required to submit cost reports so that the Department has accurate data for rate setting purposes.

3400.1.1 The Division of Audit shall perform a uniform desk review of each acceptable cost report submitted.

3400.1.2 The uniform desk review is an analysis of the provider's cost report to determine the adequacy and completeness of the report, accuracy and reasonableness of the data recorded thereon, and allowable costs.

3400.1.3 Based on the results of the uniform desk review, the Division of Audit shall:

1. Request more information,
2. Issue a final report of findings, or
3. Conduct a field audit and issue a final report of findings.

6000 RATE-SETTING

6000.1 The Department is seeking and anticipates receiving approval from the federal Centers for Medicare and Medicaid Services for this Section. Pending approval, increased reimbursement rates will be effective retroactive to July 1, 2016:

The following capitated rates apply to Appendix D services:

Intellectual Disabilities and Autism Spectrum Disorder - Level I- \$396.47 per diem
Intellectual Disabilities and Autism Spectrum Disorder - Level II- \$585.60 per diem
Child Mental Health- Level I - \$330.72 per diem
Child Mental Health – Level II - \$435.40 per diem
Crisis Stabilization Residential Services - \$539.89 per diem
Therapeutic Foster Care - \$103.51 per diem
Therapeutic Foster Care- Multidimensional - \$150.45 per diem

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6000 **RATE SETTING** (cont.)

Temporary High Intensity Service - By Report per hour

6000.2 The Department shall seek approval from the federal Centers for Medicare and Medicaid Services for this Section.

The following capitated rates apply to Appendix D services effective November 1, 2021:

Intellectual Disabilities/Developmental Disabilities Residential Treatment Facility - \$727.98 per diem

Mental Health Residential Treatment Facility - \$580.09 per diem

Aftercare Services – Service - \$53.34 per hour

Aftercare Services – Mileage - \$2.13 per mile

~~Children are assessed by the Department, as described in Chapter II, Section 97, and will be assigned to one of the categories of level of care described above.~~ Providers bill the Department on a per diem basis for each child. The capitated rate includes all PNMI services required by child for his/her category of level of care including all staffing required pursuant to State of Maine licensing guidelines, and as identified in the child's individual service plan. See Chapter II requirements for Temporary High Intensity Services. There is no cost settlement for Appendix D PNMI services.

Aftercare Services are reimbursed per hour. Aftercare Services mileage may be reimbursed per mile for staff traveling from the facility to the location of the Aftercare service and back, as applicable.

6000.23 The provider must also submit, upon request, such data, statistics, schedules, or other information that the Department requires.